Integrated Breast, Cervical and Colorectal Cancer Screening Program
Request for Applications (RFA) 1209120315

QUESTIONS AND ANSWERS

RFA Intent

1. Question: Is this the Cancer Services Program that was taken away from the counties within the last two years?

Answer: The New York State Department of Health (NYSDOH) Cancer Services Program (CSP) oversees the delivery of comprehensive breast, cervical and colorectal cancer screening and diagnostic services to eligible uninsured and underinsured individuals in NYS through local screening programs. Currently, there are 41 contracts serving every county and borough to ensure access to these needed services. A list of current contractors is provided in RFA Attachment 1, p. 46. This RFA will continue this program, funding contractors to promote comprehensive, guideline-concordant breast, cervical and colorectal cancer screening services among age-appropriate populations and to coordinate the provision of integrated cancer screening services to eligible individuals, with an emphasis on priority populations in every NYS county and borough.

Eligibility

2. Question: Is Queens Hospital Center eligible to apply for this grant?

Answer: Any organization meeting the eligibility requirements stated in the RFA (Section II, beginning on p. 6) may apply.

3. Question: In reference to Section II, Who May Apply, we would like to know if it would be possible for NYCHHC (or several hospitals in the Health and Hospitals Corporation system) can apply as one entity even if one or more of the hospitals may be in different boroughs? By doing so they pool resources but they would serve the patients of the borough that they are in (e.g Bellevue, Metropolitan-Manhattan; Lincoln-Bronx).

Answer: As a result of this RFA, the NYSDOH will award up to one contract in each of the five New York City boroughs (Bronx, Brooklyn, Queens, Staten Island, and Manhattan). NYCHHC may submit an application for each of the boroughs. Per RFA, p. 8, "…applicants applying for multiple service regions should submit one application per region. If an applicant is awarded contracts for multiple service regions, only one NYSDOH infrastructure, one NYSDOH reimbursable clinical and laboratory services and one HRI reimbursable clinical and laboratory services contract will be issued. (For Component B applicants, only one NYSDOH infrastructure contract will be issued.) Award amounts may be modified to reflect implementation of a unified, cohesive program, covering the full scope of work, staffing needs and functions throughout the revised service region."

4. Question: Question from RFA page 9 For Both Component A and Component B Applicants:

last paragraph, Preference will be given .....who have in place, or develop and implement within one year.....healthy meeting guidelines (Attachment 5). Can the contract agency have a policy for healthy meeting guidelines and not have the guidelines for vending machines and stores on the agency site?

Answer: Contractors should develop comprehensive healthy foods policies to the best of their abilities. Please note that submission of a signed Comprehensive Healthy Foods Policy Status and Intent Attestation is preferred, but not required. Applicants submitting the attestation, will be given preference points in the review of their applications.

Service Areas, Anticipated Funding Allocations and Estimated Screening Numbers (Attachment 2)

5. Question: On page 5 of the RFA, in the paragraph that begins with "Attachment 2 provides a list of the anticipated maximum…." It states the following:

Two separate potential infrastructure contract values are provided for each service region; one for those organizations currently holding CSP cancer screening partnership contracts for a designated service region and the other for organizations that do not currently hold CSP cancer screening partnership contracts for a designated service region.

If an organization holds a contract for a designated service region, submits an application for refunding for the region, and also submits an application for an additional region, is it considered an existing contractor in relation to the additional region?

Answer: No. Per RFA p. 8, "An applicant may be the lead organization on more than one application. However, applicants applying for multiple service regions should submit one application per region." In this example, if the applicant does not currently hold the contract for the service region being applied for, the applicant is not considered an existing contractor for that service region.

Please also note that as per RFA p. 8, "If an applicant is awarded contracts for multiple service regions, only one NYSDOH infrastructure, one NYSDOH reimbursable clinical and laboratory services and one HRI reimbursable clinical and laboratory services contract will be issued. (For Component B applicants, only one NYSDOH infrastructure contract will be issued.) Award amounts may be modified to reflect implementation of a unified, cohesive program, covering the full scope of work, staffing needs and functions throughout the revised service region."

6. Question: In the Hudson Valley, H.I.T.C.H. is a non-profit organization founded by three federally qualified health center systems—Hudson River Health Care, Open Door Family Medical Centers, and the Institute for Family Health. Currently, the contract for the Hudson Valley CSP is held by Hudson River Health Care on behalf of H.I.T.C.H. Under this new RFA, Open Door Family Medical Centers will be submitting the application, on behalf of H.I.T.C.H., for refunding of the HV CSP. If awarded, H.I.T.C.H. staff will continue to be responsible for program implementation. Therefore, the submission from Open Door would be considered an existing contractor, correct?

7. Question: My question has to do with whether we can apply for the Infrastructure Rate for Existing Contractors or whether must apply as a new contractor. The reason I am asking is that Newark-Wayne Community Hospital (NWCH) is currently the subcontractor that provides the infrastructure tasks under the Wayne County Public Health Department (WCPH) who is the current grant contractor. WCPH has decided NOT to apply for this competitive round of funding since they feel it costs them too much to provide the grant coordination and state voucher work related to the grant.

My staff are the data and case manager and the outreach coordinators for the subcontractor; the RGHS system are the clinical services providers as well. My staff also coordinate all partnership meetings and communications with the other CSP providers under the current contract and I do the accounting and billing for part of the infrastructure; they enter the requirements into Indus and track and apply for new provider numbers, etc. We also provide in-kind funding for the currents grant.

I ask, because if we are funded, the infrastructure pieces are in place and there would be a totally seamless transition in the grant's functions. My staff would be doing the same current work; only the fiscal piece would be different because the fiscal agent would now be NWCH instead of WCPH.

Please consider the reasons and justification for my request: Can we apply as an existing contractor?

Answer: In both instances, if the applicant organization does not currently hold the CSP screening partnership contract, the applicant organization is NOT an existing contractor; current subcontractors are NOT considered contract holders.

The applicants in this instance should therefore request infrastructure contract budgets totaling no more than the contract values listed, "FOR NEW CONTRACTORS" for their service regions, as listed on RFA pp. 51 and 52, Attachment 2.

The current CSP cancer screening partnership contracts end October 31, 2013 and new contracts awarded through this RFA are anticipated to begin July 1, 2013. The four month time period between July 1, 2013 and October 31, 2013, will be a period of transition in the event that an existing contractor does not apply or is not awarded a new contract in any service region, allowing for an overlap of contractors if necessary to facilitate a seamless as possible transition for clients and participating health care providers from the current contract holder to the new one. In these scenarios, if the current contractors do not apply or are not awarded new contracts, they will still have infrastructure funds under their existing contracts to support transition and contract close-out activities for the July 1, 2013 – October 31, 2013 time period.

8. Question: Will Component B be given dollar totals for patient services that have previously been included in HRI and DOH patient service contracts?

Answer: RFA Attachment 2, p. 52, includes the anticipated amounts to be available for provision of clinical services for eligible clients, in Component B service regions. The funds will NOT be included in contracts to the successful Component B awardees, but will instead be directly reimbursed to clinical service providers who render the services, payable either by the State and HRI or by their fiscal agent.

9. Question: I have a question regarding the Integrated Breast, Cervical, and Colorectal Cancer Screening Program RFA. On Attachment 2-Service Areas page 51, the Schenectady County funding allocations are listed as follows:

Service Area	FOR EXISTING CONTRACTORS 9 Month Pro-Rated **Infrastructure** Contract Value***** (7/1/2013-3/31/2014)	FOR NEW CONTRACTORS 9 Month Pro-Rated **Infrastructure** Contract Value***** (7/1/2013-3/31/2014)	FOR EXISTING AND NEW CONTRACTORS 9 Month **Clinical Services** Contract Value***** (State and HRI)	Estimated Number of People To Be Screened for 9 Month Period
Schenectady	$105,000	$86,333	$84,338	263

As the current contract holder, the information above relative to our current infrastructure and clinical services allocations is very low. Our screening volume for the first 9 months of this program year (04/01/12-12/21/12) was 472. Could you please review the Schenectady allocations for accuracy?

Answer: The anticipated maximum infrastructure values listed in RFA Attachment 2, pp. 51 and 52, were derived through an equitable distribution of the total anticipated available state funds relative to the eligible population of uninsured men and women at or below 250% of poverty guidelines in each service region. These estimates are improved over those used in the prior RFA; they are more reflective of the true eligible populations in each service region. The contract amounts were not based on current contract performance (i.e., current number of people screened). The infrastructure contract values were assigned at funding amounts sufficient to support the anticipated level of staffing required to implement the scope of work outlined in the RFA and to reach the estimated number of eligible persons to be provided with comprehensive cancer screening and diagnostic services in each service area.
Please note that Attachment 2 has been amended to clarify the intent of the last column regarding the estimated number of people to be provided with comprehensive services within each region. Please see Addendum II posted along with the RFA.

10. Question: Patient services annual award amounts have varied recently by as much as $65,000 annually (or roughly 25%) for our contract. Should we prepare for that in the future?

Answer: RFA Attachment 2, pp. 51 and 52, provides an estimate of the combined State and HRI clinical services allocations (please note that these are estimates only). Clinical services allocations will be based on funding availability, contractor performance, ability to provide screening and diagnostic services and expend the reimbursable clinical services allocations and compliance with all contract requirements. All actual contract values and clinical service allocations are contingent upon budget appropriations.

11. Question: Are award amounts lower due to estimated budget cuts, but they could rise if those cuts are not implemented?

Answer: The anticipated maximum infrastructure values listed in RFA Attachment 2, pp. 51 and 52, represent a 9 month period and were derived to ensure equitable distribution of funds relative to the eligible population of uninsured men and women at or below 250% of poverty guidelines in each service region. The infrastructure contract values were assigned at funding amounts sufficient to support the anticipated level of staffing required to implement the scope of work outlined in the RFA and to reach the estimated number of eligible persons to be provided with comprehensive cancer screening and diagnostic services in each service area. The contract values are based on anticipated funding amounts, contingent upon State and Federal appropriations. Changes to appropriations could result in adjustments to both infrastructure and clinical funding values. Please note that Attachment 2 has been amended to clarify the intent of the last column regarding the estimated number of people to be provided with comprehensive services within each region. Please see Addendum II posted along with the RFA.

12. Question: If many new contractors, then less patient services dollars awarded to them, would that mean more for existing contractors who have demonstrated the ability to reach more people than we have funding for?

Answer: To maximize spending of both State and federal funds, fiscal review processes are in place for the Department to identify unspent clinical funds which can be reallocated to contractors that are better able to expend them.

13. Question: Are screening goals adjusted down due to budget constraints?
14. Question: Why is the goal to screen fewer people?

Answer: The estimated number of people to be screened included in Attachment 2 (RFA, p. 51) are based on a 9 month period and reflect, "the estimated number of eligible people that could be provided with comprehensive screening and diagnostic services based on the values of the state and HRI clinical services allocations (please note that these are estimates only)." (RFA, p. 5) These are estimates of the potential number of clients that could be provided with all screening and diagnostic services for which they are eligible. Please note that Attachment 2 has been amended to clarify the intent of the last column regarding the estimated number of people to be provided with comprehensive services within each region. Please see Addendum II posted along with the RFA.

15. Question: Regarding the number of clients accepted, would the Partnership be restricted to only 2800 clients?

Answer: Applicants/contractors should maximize the number of individuals screened within the eligibility criteria and the clinical services budget. Applicants/contractors should monitor screening and diagnostic expenditures and accurately assess program eligibility to ensure that screening services occur throughout the program year, to maximize services to the target population and to align with the federal clinical practice guidelines for cancer screening services. Please see the Provision of Health Services and Fiscal Management requirements in the Scope of Work, RFA pp. 15 through 19.

16. Question: What is the methodology to arrive at contract values and screening numbers?

Answer: The infrastructure contract values were assigned funding amounts sufficient to support the anticipated level of staffing required to implement the scope of work outlined in the RFA and reach the estimated number of eligible persons to be provided with comprehensive cancer screening and diagnostic services in each service area. The contract values are based on anticipated funding amounts, contingent upon State and federal appropriations. The estimated number of people to be screened included in Attachment 2 (RFA, p. 51) are based on a 9 month period and reflect, "the estimated number of eligible people that could be provided with comprehensive screening and diagnostic services based on the values of the state and HRI clinical services allocations (please note that these are estimates only)." (RFA, p. 5) These are estimates of the potential number of clients that could be provided with all screening and diagnostic services for which they are eligible. Please note that Attachment 2 has been amended to clarify the intent of the last column regarding the estimated number of people to be provided with comprehensive services within each region. Please see Addendum II posted along with the RFA.

Scope of Work/Required Staff and Functions

17. Question: On page 19 under Required Staff a) Program Coordinator, it states the "Organization will employ a professional position,.." What is the definition of a professional person?

Answer: There are no specific licensure or education requirements for this position. Rather, applicants should ensure that, "All staff fulfilling the roles of either the Program Coordinator or other key functions should have the appropriate education and professional credentials and competencies to effectively carry out the required activities." Please refer to RFA p. 19, for a description of the Program Coordinator expectations.

18. Question: Question from RFA page 4 Component A -5th bullet from top of page 4-Contractors should employ a professional position, recommended at minimum .50 FTE, for Program Coordinator, Can this position be a subcontractor to the Contract Agency?

Answer: Per RFA, p. 19, "For Component A Applicants: The lead organization will employ a professional position, recommended at a minimum .50 FTE, for a Program Coordinator; exceptions to the recommended minimum FTE will be considered with appropriate justification." This position will be employed by the lead organization (applicant organization, contract holder) and will not be a subcontracted position.

19. Question: Please reference page 4, last paragraph, last bullet, under Component B discussing that "successful applicants under Component B will also serve as demonstration projects that will inform the implementation of future programs to increase cancer screening through health systems change interventions that seek to increase cancer screening among the general population.....once the PPACA is fully implemented".

My question regarding this: Should funds be put aside in our budget proposal to cover the costs of any additional functions required for demonstration project, or will more funds be made available to those sites chosen for demonstration project?

Answer: No. The full scope of work for Component B applicants is described in the RFA on pages 11 through 19. The infrastructure contract values listed in RFA Attachment 2, p. 51 and 52, were assigned to support the anticipated level of staffing required to implement the scope of work outlined in the RFA and reach the estimated number of eligible persons to be provided with comprehensive cancer screening and diagnostic services in each service area. This budget is intended to also cover the costs of the demonstration projects.

20. Question: As the DOH is assuming direct provider payment for Component B, what is the lead agency's fiscal responsibility?

Answer: As stated in the RFA, p. 18, the successful applicants will be responsible for the following fiscal management responsibilities:
"The lead organization will:

- Within the funding amounts set by the NYSDOH, establish fiscal and operational systems to ensure that clinical and laboratory services are provided throughout the full program year. This may be done by establishing monthly client volumes for provision of services by participating network providers
- Submit the required NYSDOH budget monitoring tool on a monthly basis (tool to be provided upon contract execution).
- Monitor the infrastructure budget to ensure that funds are expended in an appropriate manner. Prepare and submit budget modifications if necessary and in accordance with NYSDOH practices.
- On a monthly basis, prepare the budget report of expenditures and submit vouchers to the NYSDOH to ensure prompt reimbursement. Provide back-up documentation for voucher expenditures at the request of NYSDOH. Such documentation may include copies of all receipts, invoices, bills, payroll records, etc. to substantiate all personnel and other than personnel charges.
- Respond to inquiries from participating providers to reconcile payment for services rendered.
- For underinsured clients, ensure that all providers are aware of and conform to client eligibility, data submission, and billing guidelines, in accordance with the CSP Operations Manual Eligibility Section III."

21. Question: page 24 section 5(a) (ii)
What is meant by a transition plan and do we need to do this as part of the application?

Answer: Per RFA, p. 11, "Successful applicants will be provided with and should plan for a start-up period to allow sufficient time to hire staff to fulfill required functions, develop and implement operational systems and assist with the transition of clients from former contractors serving the same region, as applicable. It is anticipated that this start-up period will begin on July 1, 2013 and end no later than October 31, 2013. Under the direction of the NYSDOH, contractors will complete all transition and start-up activities prior to initiation of cancer screening services, per the "Contractor Start-up Checklist" provided as Attachment 9." This start-up period applies only to new contractors, not to current contractors who are awarded new contracts for the regions they currently serve.

Applicants should use RFA Attachment 9, Start-Up Checklist, pp. 62-64 as a guide to describe how the applicant organization will implement all transition and start-up activities prior to initiation of cancer screening services. Applicants should describe how the required transition and start-up activities will be implemented, who will implement them and the timeframe for completion of all activities. Successful applicants must complete all transition and start-up activities prior to initiation of cancer screening services, per the Start-Up Checklist. Start-up activities should be initiated beginning July 1, 2013 and completed no later than October 31, 2013. The Start-Up Checklist, RFA Attachment 9, does not have to be submitted with the application. The RFA has been amended to reflect this change; please see Addendum II posted along with the RFA.

22. Question: Under Scope of Work, page 12 13th bullet point down, what is meant by the performance management tracking system? Is this Indus?

Answer:
The performance management tracking system is NOT Indus. The Indus data system is used to collect client level information for clients receiving reimbursement for clinical services through the program. The Performance Management Tracking system will not be used for client level data, but rather it will be used to collect and submit information and data regarding broader program implementation, as well as short term and long term outcomes. As indicated in the RFA, p. 12, the system will be provided by DOH to contractors when available.

23. Question: Are DQEs required to be CSP employees, or can this cost be off-loaded to provider's patient financial reps?

Answer: Designated Qualified Entities (DQEs), who complete applications for, and enroll clients in, the Medicaid Cancer Treatment Program are not required to be employees. While it is required that grant-funded case managers be trained as DQE's, it is encouraged/recommended that appropriate staff from participating provider/facilities be trained as DQEs. Please refer to the CSP Operations Manual posted along with the RFA (Chapter 5, Case Management, #9 pp. 3 and 4).

Provider Networks

24. Question: Pg 6-ensure required activities for the entire region. How should we indicate that we want to follow the lines of the service provider networks? If OK with partners…if we arrange for contracts between each provider and all CSP how do we arrange for flexibility for the money to follow the patients?

Answer: As per RFA, p. 27, applicants should, "Describe the network of medical care providers and clinical laboratories currently in place or to be developed to provide eligible individuals with needed cancer screening, diagnostic and, when needed, treatment services. Describe how providers will be recruited and how their participation in the local screening program will be maintained. Describe plans for ensuring sufficient numbers and types of providers, throughout the service region, to meet the needs of the eligible population."

As per RFA, p. 16, the successful awardee will be responsible for the following activities related to provider networks:

"The lead organization will develop a network of medical care providers throughout the service region to provide eligible men and women with comprehensive, guideline-concordant breast, cervical and colorectal cancer screening and diagnostic services, and, when necessary, ensure access to treatment services. The lead organization will:

- Recruit and maintain a comprehensive provider network able to provide high-quality, evidence-based breast, cervical and colorectal cancer screening services to the eligible population throughout the service region.
- Ensure that written provider agreements are obtained from all network providers within two months of initiation of contract. As part of this process, secure assurance and commitment from clinical providers to accept the rates in the Maximum Allowable Reimbursement Schedule (Attachment 3) as payment in full for services rendered.
- On an ongoing basis, ensure that there are sufficient numbers and types of providers in the network to meet the needs of the eligible population for comprehensive and timely cancer screening and diagnostic services.
- Ensure network providers are licensed and appropriately qualified and credentialed, without restrictions related to providing cancer screening services, as directed by the NYSDOH."

25. Question: Will the Partnership be obligated to accept providers or can a request be made for patients to be referred to the Partnership only?

Answer: Contractors are not obligated to accept providers. As per RFA page 16, "The lead organization will develop a network of medical care providers throughout the service region to provide eligible men and women with comprehensive, guideline-concordant breast, cervical and colorectal cancer screening and diagnostic services, and, when necessary, ensure access to treatment services." And, "The lead organization will develop a network of medical care providers throughout the service region to provide eligible men and women with comprehensive, guideline-concordant breast, cervical and colorectal cancer screening and diagnostic services, and, when necessary, ensure access to treatment services."

Applicants are asked to, "Describe the network of medical care providers and clinical laboratories currently in place or to be developed to provide eligible individuals with needed cancer screening, diagnostic and, when needed, treatment services. Describe how providers will be recruited and how their participation in the local screening program will be maintained. Describe plans for ensuring sufficient numbers and types of providers, throughout the service region, to meet the needs of the eligible population." (RFA, p. 27)

26. Question: If the Partnership must accept providers, can you limit the number of providers you want?

Answer: Yes, the partnership can limit the number of providers. Applicant organizations are responsible for proposing a network of health care providers throughout the service region to provide services, ensuring sufficient numbers and types of providers to meet the needs of the eligible population.

27. Question: Do we need letters of collaboration from all of our providers or just a sampling?

Answer: Given the 10 page limit for the letters of collaboration, it may not be practicable to submit letters from all providers. Rather, per RFA, p. 29, applicants should provide letters of collaboration sufficient to demonstrate their ability to ensure sufficient number and types of providers throughout the service region to meet the needs of the eligible population, within the 10 page limit for the letters of collaboration. Applicants are also asked to describe their provider networks in their technical proposals.

The Indus Data System

28. Question: Will Indus, screening intake forms, and consent forms be revised to accommodate screening and tracking of insured clients against program goals and objectives?

Answer: The Indus data system and associated intake and follow-up forms will be used by contractors to collect and enter data pertaining to uninsured and underinsured clients receiving reimbursement for clinical services through the CSP. There are no plans at the current time to require contractors to enter data on the Indus data system regarding insured clients, nor to complete consent forms for insured clients regarding reimbursable cancer screening and diagnostic services.

29. Question: During the overlap and transition period of July 1, 2013 through October 31, 2013 will the successful applicant have Indus access to the full service region for which they apply. (For us that would mean access to Eastern and Western Queens data).

Answer: A successful applicant will have access to the data on the Indus data system for the full service region for which they are awarded during the transition period.

Application Budget

30. Question: As there are two budget guidelines for Infrastructure and for Clinical Services, does this mean that an applicant may apply to conduct just the Infrastructure or just the Clinical Services? And then collaborate with another applicant who may be conducting the complementary services? Or does one applicant have to apply to cover both, Infrastructure Services and Clinical Services. If the application has to cover both services/budgets, can we have a subcontract in the application with another organization or facility to provide part of these services?

Answer: As per the budget guidance (RFA pp. 29 and 30), applicants should prepare budgets for the total infrastructure award and should not include budgets for the clinical and laboratory services amounts in their budget calculations.

The lead organization (applicant agency) is responsible for developing a network of medical care providers throughout the service region to provide eligible men and women with comprehensive, guideline-concordant breast, cervical and colorectal cancer screening and diagnostic services. The lead organization will, “Ensure that written provider agreements are obtained from all network providers

within two months of initiation of contract. As part of this process, secure assurance and commitment from clinical providers to accept the rates in the Maximum Allowable Reimbursement Schedule (Attachment 3) as payment in full for services rendered." (RFA p. 16).

As per RFA, p. 19, Component A applicants are responsible for directly reimbursing health care providers and clinical laboratories for services rendered and therefore successful Component A awardees will receive three contracts – one state contract for infrastructure, one state contract for reimbursable clinical services and one Health Research, Inc. contract for reimbursable clinical services. Component B applicants are not responsible for direct reimbursement of health care providers; this will be done by the State, Health Research, Inc., or their designated fiscal agent. Please refer to the RFA, Scope of Work section for Component A and Component B responsibilities.

As per the RFA, p. 11, subcontracting is allowed, as follows, "Applicants may subcontract components of the scope of work (e.g., Public Education and Targeted Outreach), but it is required that the applicant retain a majority of the work in dollar value (at least 50%) of the infrastructure contract within the applicant organization. For those applicants that propose subcontracting, it is preferable to identify subcontracting agencies during the application process. Applicants should note that the lead organization (contractor) will have overall responsibility for all contract activities, including those performed by subcontractors, and will be the primary contact for the NYSDOH."

31. Question: There is no in-kind required for personnel budget? Match requirement 25% of OTPS is just for OTPS?

Answer: As per RFA, p. 34, "A match equal to .25 of the total infrastructure request should be demonstrated. (In-kind subtotal should be at least 25% of the subtotal of the amount requested from NYSDOH.)" In-kind contributions are not limited to OTPS.

32. Question: Page 30, C) Budget sections (Personnel) – are fringe benefits an allowable expense for personnel associated with the grant?

Answer: Yes, fringe benefits are an allowable expense for personnel associated with this grant.

Subcontracting

33. Question: Pg 8-letters of support from other CSP contract applicants to work together. Do we apply as a lead organization and support possible subcontracts in the future with letters of support?

Answer: As per RFA, p. 11, "Applicants may subcontract components of the scope of work (e.g., Public Education and Targeted Outreach), but it is required that the applicant retain a majority of the work in dollar value (at least 50%) of the infrastructure contract within the applicant organization. For those applicants that propose subcontracting, it is preferable to identify subcontracting agencies during the application process. Applicants should note that the lead organization (contractor) will have overall responsibility for all contract activities, including those performed by subcontractors, and will be the primary contact for the NYSDOH."

Formatting/Application Content

34. Question: We currently have a centralized intake process. What does the line mean that such applicants will receive additional consideration? Does that mean a larger infrastructure award to cover the increased cost of doing this work internally? Or is it just a preferred method?

Answer: Applications that describe a centralized client enrollment, eligibility and intake assessment processes, as described in the RFA, p. 16, will receive preference points in their application reviews.

35. Question: An organizational chart is requested for the application process. Is this an organizational chart for the Contractor or the Cancer Services Program staff?

Answer: Applicants are asked to submit organizational charts as follows: 1) As per RFA, p. 23, applicants are asked to, "Describe how this contract will fit into the applicant organization's management structure. Include (in an Attachment) an organizational chart of the applicant organization showing the location of the proposed project within the organization." 2) Applicants are also asked to, "Provide an organizational chart for the local screening program, identifying key staff, their location and reporting lines." (RFA, p. 25).

36. Question: Section IV Completing the Application- Section A. Application Content- Number 3 (Service area/population to be served) Part C Page 23:
Describe the provider and clinical laboratory demographics of the proposed service region, including the number of individual breast, cervical and colorectal cancer screening, diagnostic and treatment providers in the area. Specifically identify the number of each type of provider agreeing to participate in the program. For example, an applicant may indicate that there are 35 primary care physicians providing breast, cervical and colorectal cancer screening in the proposed service region and, of these, 21 will participate in the program.

What is the appropriate method to get an accurate count of providers in the area? Is there a resource or search engine that this type of information is available? The two sources I found NYS Physician Profile http://www.nydoctorprofile.com/dispatch and Suffolk County Medical Society http://www.scms-sam.org/index4.html, where physicians have to either be members or submit information for inclusion on the site, resulted in two extreme different counts. I would like to understand more about this requirement.

Answer:
See below, answer to Question 37.

37. Question: Is there a central resource that applicants can use to determine how many providers in the county provide cancer screening services? Or are applicants expected to survey all potential providers?

Answer:
Information may be obtained from the County Strategies and Partners Matrix for Access to Quality Health Care which was compiled from the 2010-2013 community health assessments submitted in 2009

by 36 local health departments. It describes how local health departments collaborate with hospitals and community organizations to plan and address this priority to improve population health outcomes (http://www.health.ny.gov/prevention/prevention_agenda/strategies/).
Additional information regarding provider networks is available through the health plans that serve your area (http://www.nyhpa.org/).
In addition, information may be available through the Health Resources Services Administration (HRSA) web site. HRSA develops shortage designation criteria and uses them to decide whether or not a geographic area, population group or facility is a Health Professional Shortage Area or a Medically Underserved Area or Population (http://datawarehouse.hrsa.gov/hpsadetail.aspx#Reports).

38. Question: As Component B has thirteen additional sub-sections to answer as compared with Component A, can there be any added page allowance for Component B? (page 15)

Answer: Page limits for the Technical Proposal and Work Plan application sections have been increased for Component B applicants, but remain the same for Component A applicants, as follows:

Page 24

(5) Technical proposal
Component A Maximum 10 pages
Component B Maximum 13 pages

Page 28

(6) Work Plan
Component A Maximum 15 pages
Component B Maximum 18 pages

The RFA has been amended to reflect this change; please see Addendum II posted along with the RFA.

39. Question: Work Plan Goal 3a - If we are deemed Component A, is this page included in our 15 page limit for the work plan? If not, how do we delete this page or will it just not be counted in our page totals?

Answer:
Component A applicants are not required to implement patient navigation strategies, but may do so as part of their proposals for implementing required in-reach strategies. Component A applicants do not need to complete Work Plan Goal 3A, but may choose to do so to describe patient navigation in-reach strategies if they opt to do so. Component A applicants who choose not to use this work plan page, should simply not complete it and it will not be counted towards the 15 page limit for Component A work plans.

40. Question: RFA page 35 B. Application Format-paragraph number two Applications should...
In this section it says applications should be typed using a 12-point font, is there a preference in font i.e. Times New Roman, Cambria, Arial, each has a 12 font size and each is not the same size.

Answer: Times New Roman 12-point is the requested font size. The RFA has been amended to reflect this change; please see Addendum II posted along with the RFA.

41. Question: page 23 #4 (a)
We do not have a Board of Directors- Do we provide from the County Exec and down, or from the Director of Health on down, or is it not necessary?

Answer: As per RFA, p. 23, applicants should include a current list of the organization's board of directors, only if applicable.

42. Question: Attachment 3 – Maximum Allowable Reimbursement Schedule – do the reimbursement amounts include both physician and facility reimbursement?

Answer: The RFA, Attachment 3, Maximum Allowable Reimbursement Schedule (pp. 54-56), represents the total reimbursement for the services listed and represents the combined technical and professional component. Please also refer to the CSP Operations Manual, Chapter 6-1, posted along with the RFA.